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No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, and HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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REPLY BRIEF OF PETITIONERS

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INTRODUCTION

In her complaint, respondent Herdrich alleged that the petitioner health maintenance organization ("HMO") and its owner physicians implemented a cost-containment mechanism that provided the HMO's owner physicians with a supplemental payment at the end of the year if the HMO successfully contained costs while providing health care to its subscribers. She claimed that implementation of this mechanism breached petitioners' fiduciary duty under the Employee Retirement Income Security Act ("ERISA") because it gave CarleCare physicians a financial incentive to withhold treatment. See Resp. Br. 9 (the "*sole focus*" of her amended complaint is the "design and administration of an undisclosed physician incentive to withhold treatment") (emphasis supplied). The court of appeals concluded that these bare allegations sufficed to state a claim for fiduciary breach.

In our opening brief, we showed that the decision of the court of appeals should be reversed. For numerous reasons, petitioners were not acting as fiduciaries when they implemented the cost-containment mechanism at issue and, even if they were, the bare allegation that such a mechanism has been adopted fails to state a claim for breach of fiduciary duty under ERISA. In opposition, Herdrich first argues that financial incentives for cost containment are not good public policy. To be sure, there is ample room for disagreement -- and ample disagreement -- about the drawbacks and benefits to the public of managed care, including cost-containment mechanisms. That policy debate is not, however, the issue here. The sole issue is whether the implementation of a managed-care program which simply reflects the alignment of the financial interests of an HMO and its owner physicians is a breach of fiduciary duty under ERISA. On that question, we show *infra*, none of Herdrich's arguments has merit.

In an *amicus* brief, the government agreed that the court of appeals' decision should be reversed, albeit not on all grounds urged by petitioners. In the course of responding to Herdrich's arguments, we also address the government's points of disagreement with petitioners' analysis.

ARGUMENT

I. PETITIONERS DID NOT ACT AS FIDUCIARIES WHEN IMPLEMENTING THE COST-CONTAINMENT MECHANISM AT ISSUE.

A. Petitioners' Cost-Containment Mechanism Is Not Governed By ERISA's Fiduciary Standards.

1. As petitioners explained in their opening brief, and as Judge Easterbrook suggested below, an ERISA "plan" is *only* the "plan, fund, or program" that is "*established or maintained by [the] employer.*" 29 U.S.C. § 1002(1) (emphasis supplied). The sole benefit of the plan "established or maintained" by State Farm is *membership* in the CarleCare HMO. See Pet. Br. 24-26. And because the CarleCare HMO was not "established" and is not "maintained" by State Farm, the CarleCare HMO's internal decisions about the arrangement or provision of health care to its members are not decisions about a benefit offered under an ERISA "plan." Hence, ERISA does not apply to those decisions.

Respondent and the government, however, contend that the benefit provided by State Farm's ERISA plan is the specific package of medical services arranged by the CarleCare HMO. Neither comes to grip with the relevant statutory language or a legislative intention reflected in that language -- to protect employee benefits by placing limits on *employers'* ability arbitrarily to restrict or deny those benefits.

First, respondent and the government argue that this Court has already determined that, even when an employer provides benefits by purchasing an insurance product, the ERISA benefits are the specific benefits provided by the insurance policy, rather than the right to the policy. It maintains that this Court's decisions in *Pilot Life Insurance* Co. v. *Dedeaux*, 481 U.S. 41 (1987), and *UNUM Life Insurance Co.* v. *Ward*, 119 S. Ct. 1380 (1999), establish that "the benefit offered in a traditional insured ERISA plan" is "the specific benefits offered under the insurance policy." Govt. Br. 24. See also Resp. Br. 34. Thus, the government asserts, it would make no sense to adopt a different rule for health insurance coverage offered through HMOs. Govt. Br. 24.

Petitioners' reading of 29 U.S.C. § 1002(1) is not in tension with the holdings of either *Pilot Life* or *UNUM*. In both cases, the parties *assumed* that the benefit offered by the ERISA "plan" included the specific benefits provided by the insurance policy purchased by the employer. The Court then proceeded on the basis of this assumption to determine whether state laws that regulated the processing of benefit claims by the insurance carrier were "saved" from federal preemption by another section of ERISA, 29 U.S.C. § 1144(b)(2), because they "regulat[ed] insurance." See *UNUM*, 119 S. Ct. at 1386-90; *Pilot Life*, 481 U.S. at 47-57. This Court did not reach out to address the validity of the parties' joint assumption, but that omission does not transform this assumption into a holding. Cf. *Lopez* v. *Monterey County*, 119 S. Ct. 693, 702 (1999) ("this Court is not bound by its prior assumptions") (citing *Brecht* v. *Abrahamson*, 507 U.S. 619, 630-31 (1993)).[1] This Court has

[1] Herdrich, but not the government, argues that petitioners' position -- that the sole "benefit" provided to her by the "employee welfare plan" in this case is HMO membership -- is also inconsistent with *Varity Corp.* v. *Howe*, 516 U.S. 489 (1996). She contends that "employing this analysis, the employees of Massey Combines would have had no cause of action because (continued...)

not yet decided how an employer's decision to provide benefits simply by arranging for the purchase of an insurance product and playing no further role affects the definition of the ERISA plan benefit provided.

In fact, extending ERISA beyond the employer-employee relationship to cover ordinary, arms-length commercial relationships such as the type at issue here would needlessly displace state law. Cf. *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 661 (1995) ("nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern"). In the government's view, when a business purchases insurance or an HMO membership for its employees, the insurance carrier or HMO is in some respects subject to ERISA's fiduciary requirements and must make certain decisions with an "eye single" to the interests of the claimant. And, state regulation would be displaced except where the insurance savings clause of ERISA applied. In contrast, if that same employee were to purchase the same insurance or HMO membership on his or her own, ERISA would not apply at all, and benefit disputes would be governed solely by state law. Thus, different regimes would govern insurers' and HMOs' conduct depending solely upon the source of payment for the coverage.

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[1](...continued)
they still had membership in the Massey Combines nonpension benefits plan." Resp. Br. 34 (footnote omitted). But, in *Varity Corp.*, Varity Corporation was "both an employer and the benefit plan's administrator." 516 U.S. at 498 (emphasis omitted). Thus, the employee benefit was a package of particular health care benefits *established and maintained by the employer*. Here, in contrast, the employer's role ends once the HMO membership is purchased by the employer and employee payments.

Second, the government observes that the House of Representatives recently passed a bill that would eliminate ERISA preemption of some state-law causes of action for damages involving HMOs. Govt. Br. 25. It suggests that the bill would not be necessary if petitioners' position -- that HMO membership is the sole benefit provided by the ERISA plan -- were correct, because there would be no preemption to eliminate. In fact, however, the proposed legislation would eliminate preemption of such state-law claims not only with respect to HMOs, but also with respect to *all providers of "insurance, administrative services, or medical services" to a group health plan*. H.R. 2990, 106th Cong. § 1302(a) (1999) (emphasis supplied). Even the government acknowledges that the provision of "medical services" under a group health plan is not preempted, see Govt. Br. 12-14, and most laws regulating insurance are expressly saved from preemption by ERISA; yet preemption of claims relating to providers of medical services and insurance would also be eliminated under the bill. This bill clearly is intended broadly to eliminate ERISA preemption without regard to the nuances of federal courts' interpretation of ERISA's complex preemption provision. In any event, the Senate counterpart of this bill contains no comparable provision, S. 1344, 106th Cong. (1999), and the proposed bill is not law.[2]

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[2] The government makes an analogous argument, citing Department of Labor regulations addressing activities that constitute plan administration within the meaning of section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). Govt. Br. 23. The regulations on their face prohibit the argument made by the government: "No inferences should be drawn regarding issues not raised which may be suggested by a particular question and answer . . . ." 29 C.F.R. § 2509.75-8. More fundamentally, these regulations do not purport to define an ERISA "plan" and thus do not determine whether the benefit "established or maintained" by State Farm is membership in the CarleCare HMO.

Finally, respondent and the government suggest that the Court should not consider this argument because, at the petition stage, petitioners acknowledged that the specific medical services they provide are benefits of an ERISA plan. See Resp. Br. 21; Govt. Br. 26. Petitioners sought review of the broad question whether amended count III of the complaint stated a claim for breach of fiduciary duty under ERISA. The acknowledgments cited were made in the context of arguments that *assumed* that medical services are ERISA plan benefits and that showed nonetheless that petitioners were not acting as fiduciaries or breaching a fiduciary duty when they implemented the cost-containment mechanism at issue. Now that this Court is addressing the merits, petitioners have fully briefed, and this Court may consider, all arguments in support of their position that the complaint failed to state a claim under ERISA. See *Yee* v. *City of Escondido*, 503 U.S. 519, 534 (1992) ("[o]nce a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below"). Consideration of this argument is especially appropriate since it was addressed by Judge Easterbrook's dissent from denial of rehearing *en banc*.

2. In any event, even assuming that the benefits under the State Farm plan are the particular medical services specified in the Group Subscription Certificate (as we do for the remainder of this reply), State Farm's decision to arrange health-care benefits through the CarleCare HMO was a plan design decision not subject to ERISA's fiduciary standards.

Herdrich is alleging that petitioners breached their fiduciary duty simply because the CarleCare HMO's owners had a financial incentive to contain costs in order to receive additional earnings. A plan sponsor's decision to provide health-care benefits through an HMO necessarily entails the implementation of cost-containment measures to reduce costs and increase earnings for the HMO and its owners. See Pet. Br.

26-28. It is therefore comprehended within the plan design decision and is not subject to ERISA's fiduciary standards. See, *e.g.*, *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996). Indeed, the Group Subscription Agreement, one of the plan documents of the plan at issue, expressly included the specific cost-containment measures alleged to constitute a fiduciary breach. Pet. Br. 28-29.

Herdrich's sole response to this argument is that petitioners, not State Farm, designed and implemented the incentive scheme. Resp. Br. 22 n.14, 28. This misses the point. State Farm decided to provide benefits through the purchase of a particular product, membership in the CarleCare HMO. The alleged incentive scheme was inherent in the decision to choose the HMO as the service provider.[3] Thus, the subject of Herdrich's allegations is a plan design decision by State Farm, and ERISA's fiduciary standards do not apply.

B. Petitioners' Implementation Of The Cost-Containment Mechanism At Issue Is Not Fiduciary In Nature.

1. In her complaint, Herdrich alleges that petitioners were acting as fiduciaries when, in order to increase their annual earnings, they "contract[ed]" with CarleCare physicians to minimize diagnostic tests and the use of non-CarleCare facilities and to "determin[e] what was or was not medically necessary."

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[3] Herdrich argues that "implementation decisions are fiduciary decisions." Resp. Br. 28 (citing, *e.g.*, *Waller* v. *Blue Cross of Cal.*, 32 F.3d 1337 (9th Cir. 1994)). In the cases cited, plan sponsors made plan termination decisions that were not subject to ERISA, but also left discretionary determinations to be made in the course of plan termination, and these determinations were deemed fiduciary because they directly affected plan benefits. In this case, the plan design decision necessarily entailed the cost-containment mechanism deemed objectionable by Herdrich. Moreover, unlike the decisions at issue in the implementation cases cited by Herdrich, none of the decisions here has any direct effect on plan benefits.

Resp. Br. 19. Both parties and the government agree that physicians' medical treatment decisions are not themselves fiduciary judgments within the meaning of ERISA. See *id.* at Br. 8-9, 24 n.16; Govt. Br. 11-13. As Herdrich explains, the "sole focus" of amended count III is the "design and administration of an undisclosed physician incentive to withhold treatment." Resp. Br. 9. The question for decision is thus whether an HMO is subject to ERISA's fiduciary standards when it establishes and implements a physician incentive to contain costs.

Thus, there is no dispute that when an HMO is providing or arranging for medical services, it is akin to any provider of services to an ERISA plan. It is neither administering nor managing an ERISA plan and thus is not acting as a fiduciary. See 29 U.S.C. § 1002(21)(A). As we described in our opening brief, any other result would virtually eliminate traditional state regulation of the practice of medicine. If ERISA were to govern the provision of health care to patients covered by ERISA plans, then state laws which govern the same area necessarily would "relate to" ERISA plans and be preempted under section 514(a), 29 U.S.C. §1144(a). See also *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 & n.10 (1997) (where a state law is a "regulation of matters of health and safety," the "'starting presumption' [is] against preemption").[4]

[4] Herdrich points out that ERISA "expand[ed] the universe of persons subject to fiduciary duties." Resp. Br. 18 (emphasis omitted) (quoting *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 262 (1993)). That is, of course, true, but ERISA also narrows the scope of a fiduciary's obligation by defining a person as a fiduciary only "to the extent" that he or she is making discretionary judgments about plan management or administration. 29 U.S.C. § 1002(21)(A). And, ERISA authorizes fiduciaries to possess dual loyalties while the common law of trusts forbids it. *See, e.g., Varity Corp.*, 516 U.S. at 498.

Conceding this, Herdrich nonetheless asserts that petitioners were administering an ERISA plan and thus acting as fiduciaries when they *contracted* with physicians under terms that might create an indirect incentive for the physician to withhold treatment. She is wrong. An HMO's decisions about how to compensate its physicians are part and parcel of its function as the arranger or provider of medical services. These decisions no more involve plan administration than do medical treatment decisions themselves. See, *e.g.*, *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 353, 360-61 (3d Cir. 1995) (holding that HMO's "selection, employment and oversight of . . . medical personnel" does not "relate to" an ERISA plan). Indeed, they are even more tenuously linked to plan administration: Medical treatment decisions may determine the nature of a benefit received pursuant to an ERISA plan, but physician compensation at best indirectly affects plan benefits. See Pet. Br. 32-35.

Moreover, state regulation of medical care extends well beyond direct regulation of treatment and "includes as well the means of compensation by which a doctor may be reimbursed for providing care to patients." Govt. Br. 17-18 & n.11 (citing state legislation addressing physician compensation). On Herdrich's view, all of this legislation would be preempted with respect to ERISA plans because ERISA governs contractual arrangements for medical services. That result would conflict with this Court's recent decisions holding that state laws regulating health care which have only an "indirect economic influence" on an ERISA plan are not preempted. See *Travelers Insurance Co.*, 514 U.S. at 659; *De Buono*, 520 U.S. at 815-16.

Finally, if an HMO's decisions about how to compensate physicians were subject to ERISA's fiduciary duty provisions, "it is difficult to understand how the HMO could function as a business entity." Govt. Br. 18. An HMO, by definition, has a

financial incentive to arrange for medical services at the least cost to itself, but, were ERISA to apply, it would be required to make compensation decisions (and numerous other operational decisions that might tangentially affect benefits) without any consideration of cost. There is nothing in ERISA that indicates a congressional intent to so cripple an HMO's ability to function as a business. Indeed, the HMO Act, which expressly authorizes HMOs to enter into risk-sharing arrangements with physicians, and other legislation strongly suggests a contrary congressional intent. See Pet. Br. 4-5.[5]

2. The government states, "to the extent the complaint in this case alleges that Carle Care physicians make discretionary decisions *in deciding claims*, it has alleged conduct that is fiduciary in nature." Govt. Br. 30-31 (emphasis supplied). And, the government continues, because some of the allegations "are phrased in terms of 'administering' the plan, rather than providing medical care, we do not read them to refer to a treating physician's determination of how to treat a patient, whether a course of treatment is sufficiently proven to be safe, or whether an emergency exists that calls for the use of particular medical emergency protocols." *Id.* at 32. Instead, the government reads the allegations to "refer to the claims administration process within the HMO, which is triggered when individuals or . . . treating physicians seek determination

[5] Herdrich implies that Congress had made incentives of the sort alleged here unlawful in the Medicare program. Resp. Br. 13. That is entirely incorrect. In the Medicare context, title 42 of the C.F.R., section 417.479, forbids "specific payment" to a physician for failing to provide medically necessary services to an individual and establishes safeguards only where incentive plans place physicians at "substantial financial risk," as defined by the regulation. Neither condition is satisfied here. And, the Medicare regulation does not apply to the CarleCare HMO in any event.

of whether particular medical services are covered by the plan." *Id.* (parentheses omitted).

For two independent reasons, however, the government's argument -- that Herdrich may have successfully pled that petitioners were acting as fiduciaries in certain limited respects -- is wrong.

First, the government appears to have misread the complaint. Herdrich's complaint is not focused on CarleCare HMO administrators' particular denials of claims for benefits. As her brief to this Court makes plain, Herdrich's allegations pertain only to *implementation of a mechanism* that provides "physician incentive[s] to withhold treatment." Resp. Br. 9; see also *id.* (describing the "sole focus" of amended count III as the "design and administration of an undisclosed physician incentive to withhold treatment").

While Herdrich uses the word "administering" in amended Count III, her brief makes clear that she is not referring to claims "administration" as defined by the Govt. Br. 20-23 -- *i.e.*, the determination of individual claims for benefits made by someone other than a patient's personal physician. And she most certainly is not alleging that "petitioners [were] act[ing] in the role of claims decisionmakers" when they engaged in the conduct at issue. *Id.* at 27. No individual physician, be it a treating physician or a physician making claims determinations, is a defendant in amended count III. Herdrich is focused on the design and implementation of a cost-containment incentive by the HMO, not on decisions about individual claims. As we show *infra*, the former actions are not fiduciary in nature.

Equally to the point, Herdrich's allegations relate only to a mechanism that may affect the decisions of *treating physicians*. Specifically, she asserts that in the CarleCare HMO treating physicians have an incentive to withhold care when

confronted with a diagnostic or treatment decision that implicates coverage, the applicable standard of care, an experimental therapy, or whether an emergency exists. Pet. App. 86a. While she refers to both the decision to implement the incentive and the physicians' treatment decisions as plan "administration," they are not. They are, respectively, business and treatment decisions, not claims determinations.

Specifically, Herdrich explains that in amended count III, she is alleging that petitioners breached their fiduciary duties by "administering the plan by determining what was or was not medically necessary." Resp. Br. 19. Under the Group Subscription Certificate § 8.3, "[t]he determination of what is or is not medically necessary is left to the judgment of the Carle physicians." Herdrich is characterizing such treatment decisions as administrative because they implicate whether a patient will receive a particular service provided under an ERISA plan, but, for reasons already explained above, such decisions do not constitute plan "administration" within the meaning of section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A). Herdrich's many statements explaining the allegations of amended count III and their "sole focus" on physician incentives to withhold treatment make plain that Herdrich's allegations concern the contracting for and implementation of incentives for physicians to withhold medical treatment from the patients under their care and not any claims administration process.

Second, Herdrich has not alleged that petitioners implemented a cost-containment mechanism that might give *administrators* (qua administrators, not personal physicians) some ownership or profit-sharing interest in the HMO and thus an indirect financial interest in the HMO's earnings. But, had she done so, she still would not have alleged that petitioners were acting as fiduciaries. Herdrich clearly did not allege that she or any other patient was wrongly denied a benefit under the plan through the claims administration process or otherwise.

She would instead be contending that petitioners put in place a cost-containment mechanism that provided some administrators with an ownership or profit-sharing interest in the HMO, thus giving them an indirect financial interest in the HMO's earnings and a tenuous incentive to deny claims.

We showed in our opening brief that this kind of business judgment, which has only an indirect effect on any plan benefit, should not be considered an act of plan administration or management and thus fiduciary in nature. Pet. Br. 32-36. All businesses, including health-care providers, seek to control costs; virtually any cost-saving mechanism may indirectly affect benefits. An HMO considers costs and earnings when it establishes an ownership structure and when it implements a compensation structure for its employees or independent contractors. Such decisions may, like many other business judgments, have some indirect effect on a benefit provided under an ERISA plan. But that cannot be the test for fiduciary status or the scope of fiduciary obligation will become unacceptably wide and vague, contravening the language, intent, and structure of ERISA, broadly preempting much state regulation of health-care providers, and discouraging HMOs and others from providing services to ERISA plans. *Id.*

In sum, amended count III does not make allegations involving the claim administration process as defined by the government. But even had Herdrich alleged that petitioners implemented a mechanism that might somehow indirectly affect claims administration, she failed to allege a fiduciary act. The implementation of business judgments that have only a potential, indirect effect on ERISA benefits does not constitute administration or management of a plan.[6]

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[6] Herdrich argues that petitioners are collaterally and judicially estopped from asserting that they are not fiduciaries, because that assertion allegedly "contradict[s] the representations they made in order to have this (continued...)

II. HERDRICH FAILED TO STATE A CLAIM FOR FIDUCIARY BREACH.

In our opening brief, we showed that allegations (i) that a CarleCare HMO physician's treatment decision might result in a cost savings for the HMO and (ii) that the same physician has some ownership interest in the HMO, do not state a claim for fiduciary breach. Pet. Br. 43-47. The government supported this analysis. See Govt. Br. 28-30.

The complaint at issue alleges only that CarleCare physicians may have conflicting financial loyalties with respect to plan beneficiaries because they are the owners of the CarleCare HMO.[7] Congress has made clear, and this Court has emphasized, that an ERISA fiduciary may have and, indeed, may act on conflicting loyalties. Pet. Br. 44 (discussing 29 U.S.C. §§ 1108(c)(3); 1002(21)(A); *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996)). The existence of such conflicting loyalties (for example, here, a physician's loyalty to plan beneficiaries and to his or her financial interest) does not state a claim under ERISA for breach of fiduciary duty:

> Under typical arrangements for employee benefit plans, such as an insured health plan where the insurance company has discretionary authority to decide claims, or a plan under which a company employee has such authority and the employer pays claims out of its own assets, there is some measure of divided loyalty on the part of a claims decisionmaker. *ERISA, however, tolerates the level of divided loyalty that is intrinsic to these common arrangements, so that ERISA plans will be created and insurance companies and others will find it practical to work for them.* [Govt. Br. 28 (emphasis supplied).][8]

Herdrich does not dispute this analysis and effectively concedes (Resp. Br. 30-33) that her allegations amount to only "[t]he mere existence of . . . a potential conflict." Govt. Br. 28. She nonetheless contends that she has stated a claim for breach of fiduciary duty under ERISA. All of her arguments lack merit.

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[5](...continued)
case removed and preempted." Resp. Br. 26. Because she bases her argument on previous assertions in this same case, she is actually invoking the law of the case doctrine. *See Arizona* v. *California*, 460 U.S. 605, 618 (1983). That doctrine is discretionary, *id.*; and neither lower court addressed it or Herdrich's estoppel arguments.

Fundamentally, Herdrich's estoppel argument assumes incorrectly that if petitioners agreed that they were fiduciaries for one purpose, they must be fiduciaries for all purposes. When Herdrich added the original count III to her complaint, she asserted that petitioners *failed to disclose* certain material facts about the financial arrangements with physicians within the HMO in violation of state law. In response, and in this context, petitioners asserted that they were fiduciaries *for this purpose* (*i.e.*, the disclosure of information related to their financial arrangements with physicians); that ERISA contained detailed disclosure requirements; and that the state-law claim was therefore preempted by ERISA. *See* Pet. App. 76a-79a. ***With respect to the allegations of amended Count III -- the count at issue here -- petitioners have steadfastly maintained that they are not fiduciaries, and both parties and the courts have addressed this question on its merits.*** In these circumstances, petitioners are not estopped from arguing that they are not fiduciaries.

[7] *See* Complaint, amended count III, Pet. App. 85a-86a.

[8] This point is the complete answer to any assertion that petitioners could avoid any ERISA difficulties by hiring independent plan administrators. Congress deliberately chose not to require ERISA fiduciaries to be free of all conflicts of interest in order to encourage the formation of ERISA plans.

A. ERISA Fiduciaries May Possess Dual Loyalties.

Herdrich first argues that although ERISA permits *plan sponsors* to operate in a dual capacity, it does not authorize other fiduciaries to do so. Resp. Br. 25. This is clearly wrong. ERISA defines a person as a fiduciary only "to the extent" that he or she has discretion with respect to plan management or administration. 29 U.S.C. § 1002(21)(A). The definition makes no distinction between plan sponsor fiduciaries and other fiduciaries, and there is no conceivable basis to engraft such a limitation onto the Act.

Indeed, Herdrich's interpretation of ERISA would make it virtually impossible for any bank, accounting firm, lawyer, or investment advisor ever to become an ERISA plan fiduciary. If she were correct, these entities would be required to make all business judgments -- not only those related to plan administration or management -- in the best interest of plan beneficiaries. And although Herdrich is "unaware of any cases in which dual capacity has been conferred upon any party other than a plan sponsor," Resp. Br. 25, the only cases on point expressly authorize non-sponsors to act as both fiduciaries and non-fiduciaries.[9] Many other cases so hold by implication when they render a non-sponsor a fiduciary for a particular purpose.

[9] *See Molasky* v. *Principal Mut. Life Ins. Co.*, 149 F.3d 881, 884-85 (8th Cir. 1998) (holding that insurance company was a fiduciary for purposes of claim review but not for purposes of notification of changes in the plan); *Kerns* v. *Benefit Trust Life Ins. Co.*, 992 F.2d 214, 217 (8th Cir. 1993) (holding that insurance company was a fiduciary for purposes of claim handling, but not for purposes of notification of a policy lapse); *Martin* v. *Feilen*, 965 F.2d 660, 669 (8th Cir. 1992) (holding that professional accountants were not fiduciaries "when providing the professional services for which they were hired," but were when they stepped outside that role and made decisions with respect to plan assets).

B. Petitioners' Cost-Containment Mechanism Is Not A Prohibited Transaction Within The Meaning Of Section 406 Of ERISA.

Although Herdrich's brief is far from clear on this point, she appears to argue that ERISA section 406, 29 U.S.C. § 1106, precludes dual loyalties (or "structural conflicts") for all fiduciaries except plan sponsors. Resp. Br. 31. She points out that section 406 categorically forbids certain types of transactions between a plan and a party-in-interest or a fiduciary even where such transactions neither result in a denial of plan benefits nor cause any harm to the plan. Moreover, she says, a fiduciary's duty of loyalty under section 404(a) of ERISA, 29 U.S.C. § 1104(a), cannot be understood without reference to section 406. From this, she concludes that section 404(a) of ERISA forbids all dual loyalties.

This argument runs contrary to ERISA's definition of fiduciary, as we have already shown. Moreover, it makes little sense on its own terms. As Herdrich points out, in section 406 Congress departed from the common law of trusts and made specifically defined conduct by fiduciaries unlawful even if that conduct did not in fact result in a denial of plan benefits or cause harm to an ERISA plan. See Resp. Br. 32-33 (acknowledging common law rule). Congress expressly *limited* such "per se" liability to the defined transactions set forth in section 406. And, elsewhere in ERISA (*e.g.*, section 3(21)(A), 29 U.S.C. § 1002(21)(A)), Congress expressly authorized fiduciaries to have dual loyalties. Herdrich's suggestion -- the extension of the limited per se rule in section 406 to forbid all dual loyalties in fiduciaries (except plan sponsors) -- is thus contrary to the language and structure of ERISA.

Herdrich may be arguing that petitioners breached section 406; that a breach of 406 also breaches section 404(a); and therefore that petitioners breached their fiduciary duty. She

did not cite this provision in her complaint, nor was section 406 addressed by the courts or the parties below. But if Herdrich is so alleging, her premise -- that the year-end supplemental payments to CarleCare physicians are prohibited transactions under section 406 -- is wrong. Critically, to state a claim under section 406, Herdrich must allege a "transaction" involving "plan" assets. See 29 U.S.C. § 1108. But as explained in petitioners' opening brief (pp. 24-26, 48-50), this plan -- like many health-benefit plans and in contrast to pension-benefit plans -- has neither a trust nor any plan assets. The plan benefits are the health care coverage provided by the HMO. But see Part I.A.1. Thus, the transactions in question -- the supplemental payments to CarleCare physicians from CarleCare HMO earnings -- do *not* implicate any plan asset or trust.

Likewise infirm is Herdrich's apparent argument that the year-end supplemental payments must be considered per se illegal because they are "excessive compensation" precluded by section 408(c) of ERISA, 29 U.S.C. § 1108(c). Section 408(c) does not define the full range of acceptable compensation schemes under ERISA. Instead, it creates a legal exemption for certain fiduciary benefit and compensation schemes that would otherwise be prohibited transactions under section 406. See 29 U.S.C. § 1106(a) (making illegal certain transactions between a plan and a party in interest "[e]xcept as provided in section 1108 of this title"). Because the supplemental payments at issue are *not* prohibited transactions under section 406, they are lawful under ERISA whether or not they are otherwise exempted from section 406 by section 408(c).[10]

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[10] In any event, Herdrich is flatly wrong when she states that the supplemental payments would not qualify for protection under section 408(c)(2). That provision excepts from section 406 "reasonable compensation for services rendered, or for the reimbursement of expenses properly rendered and actually incurred . . . except that no person so serving who already receives full-time pay from an employer . . . shall receive compensation from such (continued...)

* * * *

An allegation that a fiduciary has dual loyalties does not suffice to state a claim for breach of fiduciary duty, and that is, at best, what Herdrich alleged here.

C. Herdrich's Failure To Allege Damage To The Plan Demonstrates That She Failed To State A Claim For Fiduciary Breach Under Section 409(a) Of ERISA.

Herdrich does not allege that she was individually deprived of benefits under the plan at issue and does not seek individual relief. Instead, she brings this action "on behalf of the Plan pursuant to 29 U.S.C. 1132(a)" for an alleged violation of section 409(a), 29 U.S.C. § 1109(a). Pet. App. 85a. She claims that she alleged damage to an ERISA plan under section 409(a) because she alleged that the plan at issue had financial assets and that petitioners wrongfully depleted those assets to make the year-end supplemental payments. *Id.* at 87a. See also Resp. Br. 23-24 (stating that premiums paid to an HMO are divided into "risk pools" to cover expenses and that these risk pools are plan assets).

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[10](...continued)
plan." 29 U.S.C. § 1108(c)(2). Herdrich asserts that the "[p]etitioners are excluded from protection under 408(c)(2) because they are already paid a salary as full-time employees of Carle Clinic and/or HAMP." Resp. Br. 36. But this argument reflects confusion as to whom Herdrich has sued in amended count III of her Complaint. "Neither Dr. Pegram, nor any other individual physician, is a party defendant in Amended Count III." *Id.* at ii (citing Pet. App. 83a). Rather, Herdrich sued *Carle Clinic and HAMP themselves*, and these corporate entities are plainly not "employees." App. 83a. Thus, Carle Clinic and HAMP do not "receive[] full-time pay from an employer" and are permitted to receive "compensation for services rendered" to the plan, if such earnings, indeed, are compensation within the meaning of section 408.

But, as set forth in our opening brief (pp. 48-50) and above, the benefits of this health plan are the health-care services to be provided, not a particular monetary benefit. Nor is there any trust fund from which benefits are financed. Hence the plan at issue has no assets. As the government explains, petitioners provide services to an ERISA plan, but they are not themselves an ERISA plan and the HMO's earnings are not the assets of an ERISA plan. Govt. Br. 10-11 & n.4. Herdrich's allegations of damage thus "make no sense in ERISA terms. The year-end payments were not plan assets in the first place, and their return to the HMO would not constitute reimbursement to an ERISA plan." *Id.* at 11 n.4.

Herdrich's inability to allege any damage to an ERISA plan demonstrates that she has failed to state a claim for fiduciary breach under ERISA section 409(a).

CONCLUSION

For the reasons set forth in our opening brief and above, the decision of the court of appeals should be reversed.

Respectfully submitted,

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